The Educationally Handicapped Child

The Physician's Place in a Program to Overcome Learning Disability

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■ *Under California Assembly Bill 464, special classes may be provided by school districts for children designated as educationally handicapped. An educationally handicapped child is not mentally retarded or physically disabled. He may have neurological handicap or emotional disorder, but he must show impaired achievement in relation to his tested abilities.*

A physician may be asked to participate in the program, either as a specified member of the admissions committee of the school district or to provide a medical clearance for entrance of one of his own patients into the program.

He does a thorough history and physical examination but adds special examination of attention, activity, coordination and attitudes.

The educationally handicapped child is helped most by the physician who does not reject the idea of educational handicap even if the medical examination is negative; who treats his minor ills; who medicates, when it is indicated, for hyperactivity, distractibility or extreme anxiety; who cooperates with parents and school personnel.

CALIFORNIA PHYSICIANS whose practice includes school-age children have a new opportunity to be of service to their young patients and to the community. The Programs for the Educationally Handicapped were established in 1963 by the California Legislature under Assembly Bill 464, which specifically requests physician participation. Many physicians are uncertain just what is wanted of them. We can define the physician's function precisely within his capabilities, so that he may make an independent and valuable contribution to a multidisciplinary effort.

The development and passage of the legislation resulted from a need for special provisions for the education of children with learning handicaps due to behavioral or neurological disorders. The Education Code defines educationally handicapped minors as ". . . minors other than physically handicapped minors or mentally retarded minors who, by reason of marked learning or behavioral problems or a combination thereof, cannot receive the reasonable benefit of ordinary education and facility." (Education Code Section 6750)[14]

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This definition was further interpreted in Article 27 of Title 5 of the California Administrative Code, Section 221a: An educationally handicapped minor, eligible for admission to a program, is a minor described in Education Code 6750 whose learning problems are associated with a behavioral disorder or a neurological handicap or a combination thereof and *who exhibits a significant discrepancy between ability and achievement.*

This is not a mandatory program and whether or not a program is to be developed in an individual district is up to the district. Parents' consent is required before a child can be referred.

The program requires a highly individualized approach involving specialized techniques, requirements, equipment and environment to cope effectively with the complex learning characteristics and problems of the educationally handicapped student.[12] For many of these pupils, changes in behavior are required before effective learning can occur. Reduction in anxiety, overcoming fear of failure, controlling of impulsive behavior and learning self-control are important factors that facilitate learning. Many of the children will require additional assistance in such areas as visual and auditory perception, spatial orientation, physical coordination, motor skills, communication skills, language development and concept formation.[9] The ultimate goal is to return the pupil to full-time regular classes.

Children are identified principally by their teachers, but may be referred also by school psychologists, school nurses, private physicians, and even by parents. Selection procedures are carefully prescribed. Usually the concerned teacher, who has had the opportunity of working closely with the child in the classroom and has intimate knowledge of his difficulty, with parental permission, refers the pupil for study by the school psychologist. A medical study is required also, and it is usually done by or through the family physician, with referral to other specialists as he sees fit. A medical report form set up specifically for this study, is sent by the school to the physician. It has been found to be helpful in calling attention to the difficulties needing special remediation.[3]

Each school district appoints an admissions committee composed of a teacher, a school nurse or social worker, a school psychologist, a principal and a licensed physician with experience in working with children and representing, but not limited to, such fields as pediatrics, neurology and psychiatry. Members of this committee review the data submitted by the teacher, psychologist and the child's physician and determine whether his interest would be served by admission to the program.

Their charge is not to make a medical diagnosis, but an educational one, supported by psychological data, classroom observation and medical information. We must emphasize that the Program for Educationally Handicapped Minors is not a medical program, but an educational plan. Educators know from experience and from research studies that children with emotional problems and those with neurological handicaps profit from the identical remedial approach, so that a definitive diagnosis of either disorder is not required.[13]

The physician asked for a medical report to the admissions committee can approach this in two ways.

He can diagnose whatever degree of developmental, neurological or psychiatric deviation he sees in the child and report his purely medical opinion; or, broadening his horizon, ask for information from the school and the psychologist, correlate this with his own findings, explore the learning disorder as far as he is able, confer with the school personnel and, additionally, make recommendation as to the child's eligibility for the class and for his best management in it. If he does the latter, it is not beyond his capacity to make a diagnosis of educational handicap.

Sometimes physicians have felt obliged to rule in or out the presence of neurological handicap (more officially designated these days as minimal cerebral dysfunction) or emotional disorder. It must be noted at once that this is not in the actual request to the family physician or pediatrician; the request is for a medical clearance alone. Of course, as physicians concerned with the detection of physical and emotional disorder, they may feel a responsibility to go as far as they can in this direction. But time and training may not always make that possible. Likewise, if the child's parents wish, the physician can try to treat the disorder he finds, as well as any concurrent conditions which may contribute to the patient's trouble in attention or learning.

Much time and discussion are spent on this matter of minimal cerebral dysfunction, neurological handicap, "hyperactivity syndrome," "brain damage," a peculiar constellation of symptoms[16] involving the province of educators, psychologist and various physicians. Space does not permit a dis-

cussion of this disorder except as it applies to the screening problem. Most usefully, we can refer readers to the preliminary Report of Task Force I of the Project on Minimal Brain Dysfunction in Children, Monograph No. 3 of the National Institute of Neurological Diseases and Blindness. This study is a very careful and condensed report on "terminology and identification" of the child with this syndrome.[6] It will be followed by further research. In its present form, it presents an excellent summary of symptoms and guidelines as to the possible areas of exploration for the practitioner. The ten most frequent characteristics are cited.

The term "minimal cerebral dysfunction" was selected in part to avoid the assumption that one is dealing with "damage" to an anatomical locus in the brain. It is important not to become defensive if, for want of better terms, parents, teachers and other laymen approach the physician with talk about "brain damage" or other expressions of the pseudoscientific jargon current on this subject.

The real concern is with the child's equipment for learning, his ability to process, store and recover information appropriately. Clinically, it can be broken down into a review of his sensory equipment, his attention, his communication skills (listening, speaking, reading, writing), his perceptual apparatus, not only visual but auditory, his memory, and his higher thinking functions of abstraction and comprehension.[1] One must note his feelings about learning and about himself as a learner.[2] His parents' abilities and attitudes are relevant, too.

In actual office practice, few physicians can conduct this entire study alone, but all must, as a minimum, take an adequate history, do a careful physical examination and make some specific neurological observations; they may need an electroencephalogram if impaired or interrupted consciousness disables the child. They should note the child's attention, activity, motility, mood, temper, gross and fine coordination and expressed attitudes.[11]

It is most important not to come to negative conclusions because of the paucity of evidence on examination. Many physicians have discounted the seriousness of a child's problem because on physical and, especially on classic neurological examination, the findings are negative. One must not minimize the evidence of a carefully taken history which explores the child's prenatal and paranatal experience, his minor developmental deviations, his habit patterns and the expressed opinions of those who live with him. The teacher or principal may offer valuable observations, though they may not be tangible. Any child, and especially an educationally handicapped child, may function with great variability, both from one day to the next and in different situations.[16] This variability is one of the diagnostic signs of a child with learning problems. Physicians have been criticized[15] for denying that a problem exists, saying "nothing is wrong with him" because a child is quiet, underactive and docile on Tuesday in his office, although on Monday at school he was irritable, hyperactive and rebellious. It is odd that some negate this kind of historical data about learning or behavior when they rely so heavily on history in the absence of present signs and symptoms in peptic ulcer or allergic disease or angina.

A single test or a single kind of reading test may give a false impression of a child's reading ability.[5,10] Only a competent educational specialist can really tell if a child's ability to read is as useful to him as it should be.

Likewise, the fact of emotional disorder does not necessarily mean that the learning problem is "all emotional" or even primarily emotional, or that a referral for psychiatric care should be made before or instead of special school placement.[8]

It is also necessary to keep in mind that the children in a class for the educationally handicapped do not represent a single disability. Learning can be grossly impaired by a spectrum of handicaps which disable the child who is hyperactive, distractible and explosive, and also the one whose only abnormality may be an apparently pure reading disability.[7]

One of the physician's major responsibilities is his ability to influence parents by his professional authority. This force may decide whether parents will accept a remedial placement offered their child by the school. It is not suggested that physicians blindly accept the recommendations of teachers or psychologists. They can inform themselves as to the precise provisions of the law. Each can try to learn if and how the program is operating in his district, can appraise the professional competence of the available teachers and determine which children the particular program best serves. The physician who has done that will be better able to counsel both the parents and the

school on the advisability of a child's placement, as well as his eligibility.

Many times school and parents feel that the physician can continue his services to the child after the school placement is made. This ongoing aid consists of four things: 1) continued interest and reevaluation of the child, 2) possible specific medication if the physician feels the patient requires it, 3) treatment of the child's minor ills, and 4) ongoing support to parents, child and teacher for the best use of the program.

Many of the children are under the care of specialists for their neurological or psychiatric ailments. Parents who are unwilling or unable to arrange this, or whose children are not so ill, turn to the family physician or pediatrician, asking for medication for hyperactivity, distractibility, irritability. Many times these requests are refused, sometimes because the physician feels they have been instigated by non-medical personnel such as teachers, principals and psychologists. Naturally he will not prescribe a drug without coming to independent conclusions that it is necessary.

More and more studies show, however, that excellent results with neurologically handicapped and emotionally disturbed children can be obtained by a combination of special teaching methods and judicious medication.[5] Contrary to the belief of many, psychotherapy is rarely the treatment of choice. The careful administration of drugs as an aid to a child's comfort and efficiency in the classroom is usually greatly appreciated by the child, by his parents and by his teacher.[4] The teachers often express interest in cooperating with the physician in this regard; with the parents' permission, they ask to be informed of the medication and what it can be hoped to do. They are usually willing to make very helpful observations and reports on its efficacy. This can be a very rewarding mutual collaboration.

Since most of these children have more than one problem, it is vital that the physician and school and any other aides remain in touch and that face-to-face conferences, if possible, be held to decide what is the most fruitful order of help for the child.[10] Otherwise, the patient may be overscheduled with referrals for visual training, tutoring and motor training, at the same time that many of the difficulties for which such training is needed are being approached in a more organized way in school.

Another area of service lies in the identification and treatment of minor ills and discomforts. Because the educationally handicapped child often has problems of attention, it is important that he not be distracted from his schoolwork by his bodily sensations. The chronic sniffler, itcher or acher is entitled to relief of these sensations which he is less than normally able to ignore. This aid need not necessarily be regarded as "coddling" or as predisposing to hypochondriacal interest. Rather, the relief of minor distractions frees the child's energy for his real business of learning in school. Physicians are sometimes provoked by the insistence of parents and other laymen that they treat symptoms they have regarded as trivial in the past; sometimes a graceful concession will be needed.

But it is certain that all who work with learning problems of children wish only to further the child's ability to learn and grow. This program, if we participate properly, gives us a chance to learn and grow in our own ability to do so, while we await the results of further medical and educational research.

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